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ORIGINAL ARTICLE

The role of nurses' unions in workplace innovation in Australian and Canadian hospitals: Analysing union strategies

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Abstract

We explore the role of nurses and their unions in workplace innovation through case study research on the introduction of Lean production (LP). We find that nurses' unions were not involved in the implementation of LP. We draw conclusions about how union power, identity and narratives help explain union strategic behaviour.

1 | INTRODUCTION

In healthcare, technological advances, increasing costs and rising consumer expectations have prompted governments to seek more efficient and effective forms of quality service delivery (Radnor et al., 2012). Process redesign (PR), using lean production (LP) techniques, has become popular with hospital managers (Radnor, 2011; Waring & Bishop, 2010) and can result in significant changes to work organisation that may threaten perceived autonomy and increase work intensification of health professionals (McCann et al., 2015; Stanton et al., 2014). Unions are concerned about the effect of technology and innovation on employment, union membership, work intensity and human capital development (Doucouliagos & Laroche, 2013). However, the role of unions in the introduction and

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implementation of LP is contentious (Rinehart et al., 2018; Signoretti, 2019). Some unions view LP as a management strategy to marginalise unions, reduce employee resistance to change and increase work intensification (Stewart et al., 2010) and consequently tend to oppose LP (James, 2019; Signoretti, 2019). Alternatively, unions can embrace LP as a possible vehicle for more control over work organisation. Signoretti (2019) examined the role of union identity and how unions frame LP in the automotive parts industry in Italy and the United States. He found that union framing is underpinned by identities they derive from resources in their institutional and organisational contexts. Bamber et al. (2014) called for research to examine the extent that unions are involved in the implementation of LP.

We heed calls by Signoretti (2019, p. 129) for 'a deeper analysis of workplace unions' influence' on the implementation of LP by focusing on healthcare. In the labour-intensive, professionalised and unionised context of healthcare, unions and professional associations have the power to resist major changes to work organisation if they see such changes as against the interests of their members or patients (Bartram et al., 2020; Cregan et al., 2009). So, we might assume that unions would have some say in the implementation of LP to foster the terms and conditions of the employment of their members (Bamber et al., 2017; Shadur et al., 1995). Following Signoretti (2019), we examine how nurses and their unions in healthcare engage with the implementation of LP.

We consider evidence from the implementation of LP in three hospitals in two contexts, Australia and Canada. Our contribution is situated at the workplace level where nurses perform their work and is based on five LP projects in hospital domains such as emergency departments and wards. We compare hospitals in two health services which are similar in terms of their complex funding arrangements, industrial relations (IR) contexts, shortages of nurses and pressures to increase efficiencies.

To examine the role of nurses and their unions in LP implementation, we integrate three concepts: union power resources, union workplace identity and union narrative resources. We argue that how unions use these resources in the context of union, organisational and institutional interactions will affect the strategic capabilities and framing of LP. We draw on Ellem et al. (2020), who identify different forms of power resources that unions utilise to develop and pursue their strategies. We draw on Levesque and Murray (2013, p. 777), who argue that unions have narrative resources that 'consist of the range of values, beliefs, shared understandings, stories and ideologies that aggregate identities and interests and translate and inform motive'. An important strategic capability of unions is whether they can frame their narratives in 'the context of power relations where other actors have greater or lesser degrees and types of capability and other sources of power' (Levesque & Murray, 2013, p. 794). We also use Signoretti's (2019) concept of union workplace identity and examine its role in how unions respond to the introduction of LP.

We consider two research questions:

1. How do nurses' unions frame their responses to the implementation of lean production?
2. How do unions use their power resources, workplace identity and narrative resources to respond to such managerial changes?

We make two contributions to the IR literature. First, we explore the role of union power resources, union workplace identity and union narrative resources in nurses' unions' approach to LP, to increase understanding of the role of unions in PR and in workplace innovation more generally. Second, we offer insights into the interdependencies between unions, organisations/management and institutional arrangements in the development of unions' strategic approaches to LP.

We organise the article as follows. First, we explore key challenges in the implementation of PR in healthcare. Second, we introduce our theoretical framework; third, we outline our methodology; and fourth, we present our findings. Then we discuss the findings and draw conclusions.

2 | LITERATURE REVIEW

2.1 | Lean production, unions and healthcare

Hospitals have increasingly implemented PR innovations, such as LP, to try to make effective use of scarce resources to enhance efficiency and improve hospital performance (Radnor et al., 2012; Stanton et al., 2014). LP involves eliminating waste in processes. It is based on the system that Toyota developed to cut costs and improve quality and involves eliminating non-value-adding work (Womack & Jones, 2003). James (2019) suggests that LP is 'a holistic process of waste reduction comprised of interdependent elements, that seeks to eliminate superfluous processes, aligns processes in a continuous flow, and utilizes resources to solve problems in a never-ending process' (p. 3). It includes management practices such as 'job rotation, standardisation, quality management, broadened responsibilities and the "just-in-time" system'. James (2019, p. 4) also argues that LP is a technical set of practices, is context-free and can be transplanted 'by anyone from any place and from any type of industry'. However, Weststar and De Bona (2015) argue that the 'distinctive environmental, cultural and social elements peculiar to each context must be acknowledged, and necessary adaptations to the LP model effected, for its success in new settings' (p. 3).

Employee cooperation and teamwork are critical to the operation of LP, as are workload and working time (Signoretti, 2019). According to Pagell et al. (2014), given the emphasis on employee cooperation and participation, LP does not necessarily increase work intensity. LP may drive positive results for employees through greater participation and control, and so unions and workers may be expected to embrace such management initiatives (Signoretti, 2019). Kochan et al. (1997) suggest that LP may improve employment conditions through participative industrial relations (IR). Unions, then, could become 'full joint partners embracing the positive features of employee engagement in continuous problem-solving' and ultimately benefit employees (Signoretti, 2019, p. 128).

Alternatively, scholars have challenged such positive views and outcomes for unions and workers (Bamber et al., 2014), arguing that LP may intensify work and increase managerial control (Bamber et al., 2017; Bartram et al., 2020). Critics describe LP as 'management by stress' arguing that it 'sweats' workers through faster work processes, standardises jobs, increases social control through peer pressure and leads to a reduction in the number of workers as they do more with less (Parker & Slaughter, 1995). LP can also be a management strategy to marginalise unions by co-opting union representatives into a managerial mind-set and overcome employee resistance to change (Stewart et al., 2010). Jones et al. (2013) suggest that LP does not lead to employee empowerment and rarely leads to meaningful employee participation. James (2019) studied the implementation of LP in Toyota Australia and reported 'an acrimonious relationship between LP and the unions—as evidenced by Australia's strong manufacturing unions that posed significant challenges to Toyota's efficacious implementation of LP practices' (p. 1).

However, the adoption of LP might not be as simple as work intensification or worker empowerment (Stanton et al., 2014). Signoretti (2019) argues that union framing of LP and management ideologies may be important drivers of different outcomes. Union responses to LP reflect the management intentions of LP. In cases where managers emphasise the search for common interests of unions and managers, LP can be framed by IR actors in a positive way, such as enhancing industrial democracy and employee outcomes. Union cooperation will be reduced if managers unilaterally implement LP (Avgar et al., 2016; James, 2019). In unionised workplaces, union approaches to LP will impact their adoption and use (Dufour & Hege, 2013). Unions may encourage workplace innovation in situations where joint problem-solving can improve organisational competitiveness by promoting the active role of workers (Signoretti, 2019).

2.2 | Theoretical framework

In this paper, we use three types of union resources: power resources, union workplace identity and narrative resources to help unpack how nurses' unions frame their strategic responses to the introduction and implementation of LP in healthcare settings.

2.2.1 | Union power resources

Union strategy should be examined in the context of the interplay between the power resources that unions draw on. Power resources include associational power, structural power, institutional power and societal power. Given the relevance of union framing of LP, in this paper, we focus on associational power and institutional power. Ellem et al. (2020) describe associational power as deriving from organising, changes to union structure, coalition building, partnership, political action and international networking. Associational power of unions rests largely on the collective organisation of workers and their enthusiasm for activism and other forms of union action, especially at the workplace level. Institutional power is the enmeshing of associational and structural power (defined as 'workplace bargaining power' and 'marketplace bargaining power' [Silver, 2003, p. 13]). Schmalz and Dörre (2018, p. 6) suggest that institutional power displays 'steadfastness over time'. These authors argue that the 'power resources approach' can 'contribute to strategy building' (2018, p. 1).

2.2.2 | Union workplace identity

Signoretti (2019) focuses on union workplace identity and how this identity frames the union's response to phenomena such as the introduction of LP. Workplace union identity emerges from interactions of unions and their members with national, institutional and organisational resources and management actions (Frege & Kelly, 2003). Signoretti (2019, p. 4) argues that workplace union identity 'is constituted by ideas and ideational factors that shape both the union's approach and its actions towards employers' which are dependent on levels of collaboration or enmity between managers and union officials/members at the workplace. Workplace union identity is influenced by union micro socioeconomic circumstances and political approaches, as well as their use of and relation to macro-IR institutions (Locke, 1992).

Signoretti (2019) argues that there is a recursive interconnectedness between, on the one hand, union workplace identity and their relations with employers in the sector and, on the other hand, institutional and local level resources. IR institutions such as collective bargaining arrangements and employment laws influence union action regarding workplace innovation and change (Signoretti, 2019). Moreover, associational power in terms of union density and member support at the workplace is an important resource which will impact union workplace identity and subsequent union framing of LP (Ellem et al., 2020).

2.2.3 | Union narrative resources

Levesque and Murray (2013) argue that unions have control over their messages and that narratives matter. They suggest that 'narrative resources consist of the range of values, beliefs, shared understandings, stories and ideologies that aggregate identities and interests and translate and inform motives' (p. 777). Narrative resources are important to unions given that they can be used strategically as 'interpretative and cognitive frames' to pivot resources for the effective management of emerging challenges (2013, p. 777). Narrative resources accordingly can evoke 'pyrrhic victories' that can be used to mobilise resources (e.g., associational power), bolster hope and reinforce approaches to collective action. Such narratives can be transformative and can be used to promote strategic and collective action. Union power resources can be used to 'increase the flow and transfer of ideas, information and practices and ultimately affect that workplace union's narrative resources' (Levesque & Murray, 2013, p. 780).

We use these three aforementioned resources to examine nurse unions' framing and action with regard to the implementation of LP at workplaces. This process is discussed below.

3 | INDUSTRIAL RELATIONS AND LP IN AUSTRALIAN AND CANADIAN HEALTHCARE

In healthcare, the institutional context is important in relation to organisational change and workplace innovations. Government policy, regulation, funding and forms of collective bargaining have a direct impact on hospital practices. Hospitals operate in a context of powerful players such as regulators, unions, professional associations and consumer groups (McCann et al., 2015; Stanton et al., 2014), and we examine the implications of this institutional setting for the implementation of LP. In Australia and Canada, public hospitals are funded by a complicated system of regional (State in Australia; Province in Canada) and Federal Government funding arrangements. Regional governments have the responsibility for hospital operations, with revenue transferred from the Federal level. In Canada, IR is relatively centralised through occupationally based industry agreements that enable regional Governments to maintain control over labour costs (Archibald, 2003; Deber, 2004). In Australian hospitals, IR is enacted at the organisational level through collective agreements (CAs); however, in practice, as State Governments fund hospitals, the IR process is more centralised and the major provisions of the CAs are standardised (Stanton et al., 2010).

In both jurisdictions, hospital governing boards and managers have responsibility for human resource management (HRM) under the regional government policy and funding frameworks (Deber, 2004; Stanton et al., 2010) with nurses employed directly by the hospitals. In both contexts, there are shortages of qualified nurses, perceptions of increasing nurses'

workloads, high levels of turnover and job stress, and some substitution of nurses by less qualified workers (Cregan et al., 2009; Raymond et al., 2020).

In Australia, nurses are represented by the Australian Nursing and Midwifery Federation (ANMF), which is a professional association and a union, with a high membership density in public hospitals (Buchan, 2005). Nurses are the largest occupational group in hospitals. They have IR power and public support, which, in combination, can be challenging for authorities. Nurses are willing, when necessary, to support their union and exercise industrial power to protect their interests and those of patients (Cregan et al., 2009). The ANMF has a history of adversarial bargaining and has fought for nurses' professional qualification status to improve their pay and conditions, enhance their skills and protect their gains over control of some aspects of the labour process (Buchan, 2005). In the Australian State, the mandating of nurse–patient ratios (NPRs) in 2001 was a key victory for nurses in protecting their working conditions and patient care. The union claims that these NPRs are of such importance to nurses in this State that it has traded-off pay increases to maintain the ratios (Thomas & Chaperon, 2013). NPRs are an important element of the CA that applies to the Australian research site.

In Canada, provincial nurses' associations, supported by the Canadian Federation of Nurses Unions, represent nurses in the health system's collective bargaining at the provincial level. These provincial agreements cover key IR issues, with few conditions of employment bargained at the local level. Bargaining over wages and conditions is often adversarial. However, these agreements give managers the right to maintain discipline and efficiency and to determine the number of employees (Archibald, 2003; Raymond et al., 2020). In contrast with the Australian context, the Canadian collective agreement does not specify NPRs. Maintaining quality and safety is addressed through a process for reporting and resolving professional responsibility concerns (PRCs). The PRC process escalates from a local union and employer committee to the organisational CEO or Governing Board (Raymond et al., 2020).

Within this complex institutional context, and despite questions about its efficacy in transforming healthcare (S. G. P. Leggat et al., 2018), hospitals have increasingly applied PR using LP techniques (Radnor et al., 2012). LP appeals to managers, who often respond to the challenge of clinical leadership by rationalising clinical practices (Waring & Bishop, 2010). However, such interventions can be fragile, short-term and seen as management 'fads', thereby undermining trust (McCann et al., 2015). Furthermore, many elements of LP, such as job rotation, standardisation and just-in-time, may not be appropriate in the complex, clinical environment of healthcare (S. G. P. Leggat et al., 2018).

In many jurisdictions, governments have delegated more autonomy to hospitals and have devolved responsibilities for many functions, including HRM (Stanton et al., 2010). However, IR in many jurisdictions is still centralised, while, typically, LP interventions are introduced separately from collective agreements and unions are rarely part of decision-making (Bamber et al., 2014). Clinical staff may ignore LP interventions or use such interventions to leverage resources and achieve their own goals (McCann et al., 2015). Furthermore, LP interventions are often presented as quality improvement initiatives (Stanton et al., 2014). Reshef and Lam (1999) argue that in healthcare quality improvement is seen as a managerial initiative that is planned and implemented unilaterally by management and led by quality improvement experts. Quality of care is often understood differently by managers and clinicians. As Archibald (2003, p. 182) argues, 'nurses' unions generally tend to equate quality with hiring more nurses, paying them more, and resisting casualisation and other controversial workplace changes'. In contrast, hospital managers generally view the provision of quality of care through compliance, risk and financial lenses (Bartram et al., 2020). Reshef and Lam (1999) argue that unions act when they

perceive threats to their organisational security (threats to the union), institutional security (threat to the IR processes) or political security (threat to their members). LP initiatives that are conceptualised and implemented as a localised management initiative based on improving the quality of care may present a little apparent risk to their organisational security. Moreover, such changes may be constrained by centralised collective agreements, which may regulate how change takes place (Bartram et al., 2020).

Underpinned by our three union resources as discussed above, we theorise about the role of nurses' unions in the implementation of LP. Nurses' unions may use their power resources, especially associational power to build their narrative resources (e.g., promote stories and victories of protecting quality of patient care and members' employment standards), which may support a cohesive workplace union identity (e.g., united and vigilant around furthering and protecting employment rights and standards established in collective agreements) (Ellem et al., 2020). Powerful union narratives and a strong workplace union identity may increase the mobilisation of union members and help to further enhance associational power resources (Levesque & Murray, 2013).

These resources are critical to union's framing of organisational change such as LP implementation and the subsequent development of their approach to maintaining and enhancing members' employment outcomes. The relationship between unions (inclusive of unions' power resources, union workplace identity and narrative resources) and institutional and organisational/managerial actions is underpinned by a 'complex interdependency' (Levesque & Murray, 2013, p. 794). There is interdependency rather than a direct causality, in which there is continual interplay between the union and organisational/management action in a set of evolving institutional arrangements (Signoretti, 2019). We expand on how these resources may influence union framing of LP.

First, in relation to power resources, associational power is a vital source of power for nurses' unions which is largely supported by high union density and member activism. Institutional power of nurses' unions can be harnessed through the essential service nature of their profession, which affords them significant workplace bargaining power. We focus on the role of associational and institutional power as the main source of union power that is important in shaping nurse' unions responses to LP. Such power enables them to effectively bargain (e.g., nurses provide an essential service and have the potential to disrupt hospital operations), enforce and protect conditions of employment (e.g., nurses' union members may monitor and enable union enforcement of CAs in relation to organisational change associated with LP). Nurses' unions in Australia have a history of successful organising and member activism (Cregan et al., 2009). Moreover, nurses' unions often have the support of wider communities as they are often seen as defenders of the quality of patient care in Australia and Canada. Healthcare unions also have societal power through their capacity to network with other IR agents (e.g., other unions, community groups, advocacy groups) and to intervene in broader debates to increase their legitimacy (e.g., quality of patient care and patient safety) (Cregan et al., 2009; Dube & Thompson, 2016).

Second, in relation to union workplace identity, nurses' unions have strong union workplace identities, which gives them legitimacy in the workplace with other professionals and managers and with the wider community (Bartram et al., 2020). Such union workplace identities can be leveraged to generate member commitment and activism, which are important for policing and enforcing collective agreements at the workplace (Cregan et al., 2009), particularly in the context of organisation change such as the introduction of LP. The Australian and Canadian nurses' union workplace identities focus on their role in promoting

and galvanising members around protecting the quality of patient care and more broadly the health and wellbeing of their communities through nursing care. The Australian nurses' union protects the quality of patient care largely through protecting NPRs (maintaining and increasing the employment of nurses), whilst the Canadian nurses' union deals with this through a process for reporting and resolving PRCs, especially in relation to appropriate staffing.

Third, union narrative resources are also critical to explaining nurses' union's approach to LP. Nurses' unions, such as the ANMF, have been able to appeal to the wider purpose of patient care to build their narrative around the need for and importance of maintaining NPRs (Buchan, 2005; Cregan et al., 2009). Therefore, we might expect that any introduction of LP that affects the terms and conditions associated with collective agreements, such as workloads or staffing, will be met with union resistance. Similarly, in Canada, the nurses' union has built a narrative around protecting the quality of patient care through the PRCs (Raymond et al., 2020).

4 | METHODS

We focus on PR in hospitals in Australia and Canada. We selected the two countries because they are similar in many ways (e.g., in terms of their political economy, scale, health systems), and we were able to negotiate good research access in both countries. Such hospitals have experienced repeated reorganisations and government budget demands for higher quality services with fewer resources. Both jurisdictions saw LP as having the potential to improve operational efficiency and achieve government targets (S. G. P. Leggat et al., 2018). Our study included five projects in three hospitals in two health services in the two countries. In the Australian hospital, the LP approach was introduced and driven by the CEO through the quality improvement team and focused on particular departments. LP champions were identified and trained to the black belt level. A change in CEO saw the introduction of a range of other LP-type initiatives, for example, the Productive Wards initiative. In the Canadian province, the initiative was driven at the Provincial level through the development of 'One Province Way', an LP-inspired model that was introduced in many hospitals through a PR team. In each context, the hospital leaders identified and trained LP champions.

We used qualitative methods to elicit a rich source of data. Data collection and analysis took place from 2012 to 2015. This included individual and group interviews, key documents, field notes, meetings, informal conversations, observations, presentations and report-back sessions. We visited the sites many times partly to conduct interviews and also workshops, presentations and webinars. In 2016, the findings from all five projects were synthesised and shared with our research partners to receive feedback to assist our analysis.

There were 144 formal interviews with 125 interviewees, 57 in Canada and 87 in Australia. Some of the same participants were interviewed more than once in the course of the project. The interviews were a rich source of information and allowed for suitable crosschecks of data. Triangulation of several data sources allows for multiple perceptions about a particular case and provides validity as researchers search for convergences among multiple and different sources of information (Healy & Perry, 2000). The interview questions were designed to obtain an in-depth view of the perception of the participants of the change processes and outcomes. The validity of the data was assured through cross-checking of the data generated from different interview subjects and recursive questioning (Silverman, 2010). Interviews lasted between 60 and 90 min and, with the permission of interviewees, were recorded.

TABLE 1 Percentage breakdown of hospital interviewees by role

	Senior manager	Manager	Clinical staff
Australia	27.5%	46%	26.5%
Canada	23%	51%	26%

TABLE 2 Percentage breakdown of interviewees by occupational background

	Doctor	Nurse	PR	Allied health	Other
Australia	20%	67%	3.5%	3.5%	6%
Canada	7%	63%	21%	5%	4%

In Canada, we identified two projects through discussions with the project sponsors. The first was the Emergency Department Canada (EDC) which focused on the Emergency Department of a Tertiary Hospital. The second was a Cancer Hospital (CH) which had a whole of hospital approach to LP. In Australia, the health service had several types of LP interventions; through discussions with the project sponsors, we identified three LP interventions. The first was in an Emergency Department (EDA), the second a Productive Wards Initiative (PW) and the third was a small Specialist Service Project (SSP).

We sourced interviewees using a 'snowball' approach. First, the project sponsors identified key stakeholders and these stakeholders nominated other people who they thought would have relevant insights. To try to give a variety of perspectives in the EDA, we interviewed LP detractors, as well as LP advocates. Interviews were conducted with regard to each project until we reached saturation (when we were no longer collecting new insights). To preserve their anonymity, we identified interviewees with a code.

As shown in Tables 1 and 2, interviewees included Senior Managers, for example, CEOs and Directors; Middle Managers, for example, Nurse Unit Managers; and clinical staff, for example, nurses, doctors, allied health professionals (e.g., social workers, medical scientists, physiotherapists) and PR consultants. There was also a range of other interviewees, some formal and some informal, including health department staff, union and professional association officials and an HRM Director. No one from the leadership of either union agreed to be interviewed for this project.

All interviews were recorded and transcribed, then entered into NVivo with key descriptors identified, including country, project, role, background and relationship to PR. Similarly, in the early stages of the project, we developed a coding framework. We linked this framework to the research questions and emerging themes from the data using content analysis and thematic analysis (Joffe & Yardley, 2004). As the project developed and increased in complexity, we used the search function in NVivo to explore new and emerging themes.

5 | KEY FINDINGS

The first key finding is that the nurses' unions in both countries were not involved in PR implementation at the hospital level. In the Australian case, this was clearly stated by the HR Director of the hospital and a key nurses' union official declined a formal interview stating that

she had had no formal involvement in the implementation and therefore had no comments to make. Instead, all interviewees stated that the organisational development and learning and development activities related to the LP implementation were facilitated by the Quality Improvement team through the LP champions. However, the State health sector CAs specify detailed procedures for organisational change, and the HRM Director gave an example of how these provisions had been used in the PR processes by another union in the hospital. This was in terms of stopping a change from happening due to a breach of the formal consultation process, rather than active engagement with LP.

In nursing, the union's presence was also clearly felt at the workplace level through both the organisational change clauses in the CA and the NPRs. One Nurse Unit Manager who was also a union delegate described how an LP initiative was introduced without union involvement because it did not impact any issues covered by the organisational change clause. However, she stated, 'if … any of the solutions would have affected the way we did business …it would have been dramatically different' (NUM1PW2).

Most of the Australian nurse interviewees were familiar with the CA and identified elements that had a direct impact on the LP initiative. These tended to be around any potential increases in workload and or any reduction in jobs. However, nurses felt protected by the NPRs. They spoke about the importance of the NPRs in keeping their workloads under control, in spite of PR managerial initiatives. The CA includes clear specifications for the NPRs, and the nurses referred to the perceived protections of the NPRs. For example:

> …the best thing that happened – to nurses … is the NPR. (Nurse ED)

> … we actually get to focus more on patient care than before…from the NPRs. (NursePW1)

When there were problems there was an assumption that the union would get involved and use the NPR provision to solve the problem:

> Not enough nursing staff overnight…the union is probably being involved in this. There's only three [nurses] for 22 patients overnight. (Nurse SSP)

The Nurse Unit Managers (NUM) were also very strong supporters of the NPRs one arguing:

'I knew that if I didn't stand up for my staff they're not going to be there if I let the NPRs go' (NUM1PW1).

She also stated: 'if the NPRs had gone I would have gone too', suggesting that she believed that NPRs are a key issue in the retention of nurses and consequently the quality of care.

The NUMs interviewed were strong union supporters. NUM1PW1, who was also a union delegate, argued that nurses perceived that the union defended them in workload issues and how this narrative enables them to recruit new nurses to the union. She elaborated:

> I do nothing to recruit any of my staff to the union. I do nothing other than put up notices – …actions speak louder than words…I try to support them in every way possible, I try to give them what they are entitled to…. I follow the rules on any issues and I support them to the hilt because without them I am nothing. (NUM1PW1)

In Canada, there was also a lack of union involvement in the introduction of LP. A senior member of the Canadian Nursing Association—a professional body—said that when LP was first introduced there some years earlier, it was in the context of budget cuts and the union opposed it. She claimed that when LP was decoupled from budget cuts, the union chose not to be further involved. She stated that 'the nurses' union focuses on jobs and employee safety', demonstrating that in Canada, as in Australia, the nurses' union could be very adversarial where jobs, working conditions and safety were threatened. This was further highlighted by an interviewee from the health department's Workforce Research and Development Unit. A major workforce transformation project had just been announced. The interviewee commented that 'unions are very involved around the staff-mix changes as they (the changes) have to be contract compliant'.

The second finding was the lack of HRM involvement in Canadian hospitals. In Australia, the HR Director claimed that PR was a strategic priority of the hospital and she had played a key role in its adoption. She also claimed that an HR Business Partner was attached to each LP project. In Canada, no HR or IR managers, either in the hospitals or from the Province, agreed to be interviewed and appeared to wonder why they were being asked. The Project Sponsor did not understand why we wished to interview HR or IR managers, arguing that doing so was 'scope creep'. Despite the earlier industrial dispute in relation to PR due to concerns about staffing levels and budget cuts, the PR Team appeared to have little knowledge or understanding of the HRM function or the value of engaging with the unions. There was a lack of strategic engagement from an HRM or an IR perspective and the introduction of LP was generally seen to be a management prerogative.

> I'm sure they [the union] are [interested in PR]. But they actually don't have the ability to say No. It's the employer's responsibility and right to say what your staffing mix will be. (PR Consultant1)

This was confirmed by two union representatives that we interviewed in one of the hospitals. Both claimed to have asked the PR staff for permission to participate in the LP process but were told that their input was not required, either as a nurse in the area or as a union representative.

However, the third finding was that the centralised IR rules are important in both jurisdictions. In the Australian case, organisational change was underpinned by IR rules enshrined in the CA. This was the same in the Canadian case. Canadian nurses and managers consistently spoke about the importance of following the processes outlined in the CA, particularly in relation to any shift or roster changes. The managers were generally knowledgeable about the CA and appeared to know when and how the union should be consulted. There could be costly consequences to any breach of the CA and the staff and managers were conscious of this. The CA was an important tool in constraining management action in the PR initiative.

> You cannot change a SOP (standard operating procedure). You cannot change the scheduling of staff, you have to give notice through the union for six weeks or 12 weeks. (PR Consultant1)

> It's a unionised environment, we didn't do anything against the collective agreement. (Nurse Manager CH)

The union officials in one hospital said some of the PR consultants had no knowledge of PRCs and so faced problems when they tried to implement some initiatives. One gave an example of where she had to step in:

> I said you might want to talk to me before you start implementing something that will affect what was agreed to in writing. (Union delegate1)

And a nurse manager in the Cancer Hospital reported that she had been visited by the union to check that the PR changes had followed the rules of the CA.

> The union … came to see if I had done my rotations right and if I had…given proper notice. And because I hadn't given proper notice, what was I doing about it… (NUM2 CH)

The union delegates also claimed that there had been substantial increases in the number of PRCs the union was receiving. One stated:

> …from the union perspective there's been more [PRC] complaints in the last two years. I've [been] … overwhelmed with the number….it's a challenge to work through them. (Union delegate1)

However, both informants suggested that it was not always clear whether these grievances and PRCs were related solely to the LP intervention and Union delegate 2 stated that 'it is a wider system problem'. Moreover, they were involved in monthly union–management meetings which discussed what they termed as 'global issues' not particularly related to LP. They both felt that management respected their input into these meetings and genuine consultation around of a range of local workplace issues took place.

In short, in both countries, LP innovations were led by consultants and/or by clinicians with LP expertise, with little or no involvement of unions. The nurses' unions in both countries did not have a formal role in PR either at the institutional or the workplace level. However, strong CAs at the institutional level established clear rules in relation to organisational change and, in the case of Australia, workload. All parties felt union presence at the workplace level if IR rules were breached. Australian and Canadian nurses had different mechanisms to protect jobs and workload. While nurses in both contexts relied on their CAs, we found that the union's stances on the quality and safety of care led to different results in Canada and Australia in PR implementation. The NPRs in Australia acted as a stronger constraint than the PRCs in Canada. Since there were legislated NPRs in Australia, it was generally unnecessary there for nurses to invoke grievance processes.

This project did not evaluate the LP projects as such; however, we did capture a range of views on the successes and challenges of the projects. In Canada, some of the NUMs felt that the LP projects had given them more time to spend with their staff while others felt that initiatives such as value stream mapping took up a lot of their time which was not sufficiently resourced. Managers also identified a lack of accurate, up-to-date data and poor accountability processes. There were also unintended consequences, for example, in the Canadian ED project while there was evidence that the ED had become more efficient due to the LP interventions and increased patient throughput, putting more pressure on the medical wards led to conflict between the NUMs of the different departments. However, these only became union issues if they led to a breach of the CA.

6 | DISCUSSION AND CONCLUSIONS

We considered two research questions:

1. How do nurses' unions frame their responses to the implementation of lean production?
2. How do unions use their power resources, workplace identity and narrative resources to respond to such managerial challenges?

We draw three key conclusions. First, the nurses' unions in this study used their considerable power resources, especially associational and institutional power to focus on making the rules at the institutional level and consequently were not directly involved in the implementation of LP at the workplace level. Unions became involved only if there was a breach of the collectively agreed rules. The union strategy focused on strengthening the rules at the institutional level. The rules were well-established, and well understood by the nurses and nurse managers (most of whom were union members). Furthermore, involvement in quality improvement and other managerial initiatives in individual hospitals would require substantial union resources that are scarce (Dube & Thompson, 2016; Reshef & Lam, 1999). A strategic focus at the macro level was a better use of scarce resources.

Second, nurses' unions used their power resources to build their narrative capability to embed their message and further strengthen and reinforce union workplace identity. Their narrative was clear—protecting jobs and nurse workloads also protects the quality of patient care. The union workplace identity was underpinned by a strong sense of individual and collective responsibility to protect jobs and nurse workloads in response to organisational change. The union's strategic approach to LP was framed in these terms; if the introduction of LP did not contravene the CA, then the unions did not get involved.

Nurses and their managers internalise and police CA rules that impact the implementation of LP. Managers generally viewed PR activities as strategies to improve the operating efficiency of the hospital, which were important in minimising the potential of future budget cuts. The nurses' unions had a protectionist strategy—protecting their members' interests but claiming simultaneously to protect the interest of their patients (Buchan, 2005). Interestingly, we encountered nurse managers who were not only union members, but also union delegates.

Third, the seemingly effective use of union associative and institutional power resources, use of union narrative resources and strong workplace union identity, means that there was no need for the unions to be directly involved in LP and similar interventions—members police the IR rules and act if the rules are broken. This demonstrates the value of understanding union activities in situ. This is especially important in a sector fraught with complex institutional and political realities (Waring & Bishop, 2010). In healthcare, with its professionalised and politically savvy 'tribes' of clinicians, workers invoke unions to protect their own interests and use workplace innovation to solve their problems in their way (Bartram et al., 2020). Our study has demonstrated the importance of union workplace identity, associative and institutional power resources and narrative resources in framing union's strategic approach to LP (Cregan et al., 2009; Dube & Thompson, 2016), with nurses' unions remaining a silent partner to workplace innovation. These unions use their scarce resources to focus on their long-term relevance through maintaining and improving CAs for their members at the institutional level (Buchan, 2005; Cregan et al., 2009). Through these agreements and a mobilised membership, they can influence enterprise-level IR and management policies and practices. Unless agreements are contravened, they are able to leave change and innovation to clinicians at the workplace level. We did not find any evidence that nurses were worse off after the

implementation of LP because of the general adherence to the CAs by managers (often union members) and the policing of the implementation of LP by nurse union members themselves. We argue that this is the product of associational union power, strong union workplace identity and powerful narratives. We did, however, find some evidence of tensions and pressures on managers.

7 | THEORETICAL CONTRIBUTIONS

Our paper makes an important theoretical contribution to the union strategy literature by integrating three important resources; union power, union workplace identity and union narratives to explain union strategic behaviour in response to management-initiated organisational change. We examine how these three resources are used in the broader context of the complex interdependent relationship between unions, organisational resources and actions, and institutional arrangements (Ellem et al., 2020; Signoretti, 2019). Union strategic capacity is constructed, and union action takes place through the interaction of such resources in a broader union, organisational and institutional context (Levesque & Murray, 2013). We have unpacked the process through which unions make strategic decisions regarding their involvement in LP at workplaces (James, 2019) and specifically workplace change in the healthcare context (Bartram et al., 2020; McCann et al., 2015). We argue that a strong workplace union identity may be underpinned by associational and institutional power and the capability to develop and harness a powerful union narrative (Levesque & Murray, 2013). The relationship between the resources is largely interdependent and may be cyclically reinforcing.

The effective use of these three resources is critical to guiding union strategy and related member activity, such as policing collective agreements for any breach associated with LP. Nurses' unions have significant power, derived especially from associational (e.g., high union density and willingness to act), institutional (e.g., nurses provide an essential service and are a respected IR actor) and societal forms of power (e.g. community support to maintain high quality of patient care) (Ellem et al., 2020). This power in some respects is partly derived from and also a consequence of nurses' unions' ability to successfully develop their narrative around protecting jobs and workloads (Levesque & Murray, 2013), which equates to a better quality of patient care which contributes to such an identity for strong nurses' unions (Cregan et al., 2009; Dube & Thompson, 2016). Consequently, nurses' union members are vigilant of any attempt by management to intensify work and/or reduce nurse numbers (Buchan, 2005). Nurses' union narratives are such a powerful strategic tool because they galvanise and engage union members (nurse managers and nurses) to police organisational change. Consequently, nurses' unions focus their strategic efforts on developing CAs that protect jobs and workloads (e.g., in Australia NPRs) and do not get involved in the micro-management of the implementation LP.

8 | IMPLICATIONS FOR UNION OFFICIALS

Our analysis has implications for union officials. First, there is an important role for associational and institutional power, strong workplace union identity and union narrative resources in the development of union strategic capabilities to frame union responses to organisational change. We argue that union officials have an important role in promoting union workplace identity, and further promoting a strong union narrative that integrates protecting union members' interests whilst promoting societal interests (e.g., quality of patient

care). This can be important to recruit new members and mobilise existing members (Cregan et al., 2009; Dube & Thompson, 2016) around organisational change and its potential or perceived threat to employment conditions. Second, our analysis demonstrates in the public healthcare context, in Australia and Canada, that traditional approaches to collective bargaining and engagement with IR institutions remain essential mechanisms to manage organisational change by setting the parameters of such change. Third, union workplace identity and the ability to promote an appealing union narrative around protecting jobs and workloads is critical to mobilisation and activism, and further enhancing union power (i.e., nurse union members policing organisational change and the implementation of LP) (Bartram et al., 2020). Importantly, many nurse members are in positions of power and influence in hospital managerial hierarchies, which further enhances union's ability to police LP.

9 | LIMITATIONS

This study has limitations. We interviewed more managers than front-line staff for this study; hence, frontline employee voices are less represented than managerial voices in our analysis. Further, as with all case studies and qualitative research, there are issues of generalisability to a wider population. Despite the richness of our data and the changes in public health systems in response to government policy, it is difficult to isolate completely the impact of the PR initiatives from any confounders. Despite such limitations, we captured many voices of people involved in these PR projects in two contexts and have contributed novel insights into union strategy and the framing of LP in healthcare.

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